



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

ERIC J COLIGADO MD  
350 WESTPARK WAY SUITE 121  
EULESS TX 76040

#### **Carrier's Austin Representative Box**

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#### **Respondent Name**

NEW HAMPSHIRE INSURANCE CO

#### **MFDR Date Received**

MAY 2, 2011

#### **MFDR Tracking Number**

M4-11-2944-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** 1<sup>st</sup> correspondence dated April 28, 2011: "...We received a payment of \$240.00 for the MMI (99455-V4) part of the exam and work status report DWC 73 (99080-73). Gallagher Bassett over paid the MMI part of the exam by \$62.40, but did not pay on the three (3) area ROM IR part of the exam. I therefore request the payment of \$537.60 as per the TDI-DWC medical fee guideline for the three (3) area ROM IR/MMI using the ROM method exam."

The 2<sup>nd</sup> correspondence dated May 18, 2011: "...Our office is not disputing the MMI part of the evaluation. Our office is disputing the IR part of the evaluation. Once Dr. Coligado determined MMI was reached (99455-V4); an IR of three (3) body regions (99455-W5-WP x3, upper extremity, lower extremity, and spine) was performed and assessed."

...Dr. Coligado did bill with the correct modifiers and the IR portion of the exam has been denied incorrectly."

**Amount in Dispute:** \$537.60

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** 1st correspondence from Table of Disputed Services response received May 13<sup>th</sup>, 2011: "code is inconsistent & modifier/modifier for this claim lacks information."

The 2<sup>nd</sup> correspondence received May 17, 2011: "The Carrier has re-reviewed the providers billing and corrected billing and has been determined the line for 99455 in the amount of 900.00 has been denied correctly...Once a corrected billing is received, we will re-process the bill accordingly."

**Response Submitted by:** PAPPAS & SUCHMA, P.C. for New Hampshire Insurance Co., P. O. Box 66655, Austin, TX 78766

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2011	99455-W5-WP (originally billed as 99455-WP)	\$537.60	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 22, 2011

- 4 – (4) – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
- W1 – (W1) – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 21 – (217) – BASED ON PAYER REASONABLE AND CUSTOMARY FEES, NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT.

Explanation of benefits dated April 7, 2011

- (4) – no denial or payment reason found on EOB provided
- (21) – no denial or payment reason found on EOB provided

Explanation of benefits dated April 22, 2011

- 4 – (4) – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
- 16 – (16) – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
- BL – (BL) – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL.

### **Issues**

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Has the requestor utilized proper modifiers for the billing of a treating doctor Maximum Medical Improvement (MMI)/Impairment Rating (IR) billing?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

### **Findings**

1. The insurance carrier reduced or denied disputed services with reason code, "21 – (217) – BASED ON PAYER REASONABLE AND CUSTOMARY FEES, NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.204(j)(3)(A)(i & ii) and §134.204 (j)(4)(A & C) states:  
Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:  
(3) The following applies for billing and reimbursement of an MMI evaluation.  
(A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.  
(i) Reimbursement shall be the applicable established patient office visit level associated with the examination.  
(ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.  
(4) The following applies for billing and reimbursement of an IR evaluation.  
(A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas:

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows:

(i) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4<sup>th</sup> edition is used.

(II) If full physical evaluation, with range of motion, is performed:

(-a-) \$300 for the first musculoskeletal body area; and

(-b-) \$150 for each additional musculoskeletal body area

Texas Administrative Code §134.204(n) defines in (14), (18), and (20) the modifiers used in this billing.

The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes.

(14) V4, Level of MMI for Treating Doctor – This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to “moderate to high severity” level and of at least 25 minutes duration.

(18) WP, Whole Procedure – This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP.

(20) W5, Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement – This modifier shall be added to the appropriated examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of maximum medical improvement.

The CPT code 99455-V4 and 99455-WP billed by requestor on two separate line items are reviewed. Review of the requestor’s submitted documentation supports that the disputed examination was performed by the treating doctor. However, the requestor billed using modifier W5 on the CMS-1500 indicating the examination was performed by a designated doctor. Any reimbursement methodology allowance per 28 Texas Administrative Code §134.204 for individual services was contingent upon the use of the modifiers explained in the entire rule. The medical bills submitted by the requestor for review does contain CPT codes that do not reflect that the appropriate modifiers were applied according to the rule.

Per 28 Texas Administrative Code §134.204 (j)(6):

(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

(2) An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title.

(C ) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance paragraphs (3) and (4) of this subsection.

The requestor is the injured employee’s treating doctor, not the designated doctor, therefore, applicable to the above rules. The requestor submitted a billing for \$900.00 for the IR portion of the examination using code 99455-WP. The requestor submitted an additional line item billing in the amount of \$225.00 using code 99455-V4 (level 4 office visit) for the MMI portion. The respondent paid for the MMI portion with the amount of \$255.00 but denied the IR portion for the (3) three musculoskeletal body areas billed. Review of the documentation supports that MMI was assigned and is reimbursed per 28 Texas Administrative Code §134.203 (c)(1) for the equivalent CPT code of 99214 office visit level by the service location of Euless, TX, in zip code 76040 (Tarrant County) which has a MAR of \$162.59. The medical bills submitted by the requestor for review of the IR portion of the examination billed, reflected inappropriate modifiers were applied according to the rule, therefore, reimbursement is disallowed.

3. The respondent has reimbursed \$225.00, therefore, no additional reimbursement is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

_____	_____	September 13, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**